State of California

Department of Justice
1425 River Park Dr., Suite 300
Sacramento, CA 95815-4524

M e m o r a n d u m

To: Daniel Skillman, Administrator
Florin Healthcare Center
7400 24th Street
Sacramento, CA 95822

Date: December 29, 2011

Telephone: (916) 263-0864
FACSIMILE: (916) 263-0855

From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

The Operation Guardians team conducted a surprise inspection of Florin Healthcare Center, Sacramento, on November 29, 2011. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. During the inspection at 8:00 AM, Resident 11-03-01 was observed lying in bed moaning and holding her head. We asked her if she was in pain, and the resident did not speak English. A staff member was sitting at the bedside of the resident's roommate, and we inquired if she knew what might be wrong with the resident. This RNA stated she knew nothing about the resident as she was not on her treatment list and did not know how long the resident had been in pain. The resident's charge nurse was called to the bedside and was asked how the resident communicated with staff. The charge nurses said that hand signs were used to communicate. If the resident rubbed her head, she had a headache, if she rubbed her legs, she had leg pain. The charge nurse said she would give the resident Tylenol. However, it appeared to the OG team that the resident was trying to communicate that something else was wrong. The charge nurse and several certified nurse aids (CNA) tried to discover what else was bothering her, but were unable to understand what she was saying. They obtained her vital signs, which were within normal limits. The OG staff was then informed that an Activities Aid could speak the resident's language so she was brought to the room and the resident told her that she was having chest pain. This was a new condition for this resident and the physician was called and new orders given. She was given Vicodin for pain, which was already on her list of medications. We observed the resident asleep within 30 minutes.

This resident missed her breakfast because of the time spent evaluating her condition. But the staff stated they gave her Ensure before she fell asleep. The OG staff monitored the resident approximately every 30 minutes during the rest of the morning. The resident was found awake during lunch service but wasn't eating. We later learned the resident's family brought her rice for lunch.

The resident's chart was reviewed and there was no care plan regarding communication issues. When the Activities Aid was not on duty, there was no one that could communicate with this resident, except by hand signs. This was a major concern. Staff must be able to communicate

with residents, either through a communication board or some other device. This is a quality of care issue, and potential neglect situation.

Resident 11-03-01 did not have a Florin Healthcare identification bracelet. She did, however; have a bracelet from Kaiser Hospital. When reviewing this resident's chart, it was noted that this resident had been in Kaiser three months prior to our visit.

2. Resident 11-01-02 was observed during the morning walk-through. He was sitting up in bed, and had an amputation of his right arm above the elbow. A blue pressure pad call light was on his pillow on the right side of his head. When the resident was asked if he was able to use his call light, he was unable to speak but raised his right stump trying to hit the pad. He was unable to hit the pad because it was not positioned so he could reach it. His CNA was called into his room and adjusted the pad. He then was able to press the call light but it was broken and no light appeared when it was pressed. The CNA stated she would report the call light issue to maintenance for repair. The OG team was in his room after lunch and the resident was waving his right arm stump. The resident was asked if he needed something and he nodded yes. He attempted to raise his arm to press the blue pad but it was **again** out of reach. The pad was pressed for him and the call light had been repaired. The call light must be accessible for the resident at all times and in working order. This is a quality of care issue and potential neglect situation.

3. During the walk-through of the facility, Resident 11-02-03 was sitting by his bed in his wheelchair. The resident stated to the OG team that he hated the facility. He had been sent from the Veterans Hospital and he did not know why he was here. He stated the facility was dirty, the food was bad, the noise and confusion made him nervous and he wanted to leave. We also observed that he had a Veterans Hospital wristband on, even though he had been at the facility for four days. The team observed the room floor and tiles were dirty. The baseboards were missing, the walls were dirty and there was some liquid that had been spilled on the wall but not cleaned.

Resident 11-02-3 had Diabetes Mellitus Type II and received fingersitck blood sugars with sliding scale insulin coverage before meals and at bedtime. His blood sugars were requiring from 0 to 4 units of regular insulin before meals. He had long acting insulin at bedtime but was not on any oral hypoglycemic medication. According to the chart, the resident was receiving Physical and Occupational Therapy which could also be provided on an out-patient basis. There were no Social Services notes written about about what the resident's goals were for discharge.

After reviewing the chart and the resident's level of care needs, the team was unclear why this resident couldn't be discharged home. Nothing in the chart indicated that staff was assessing this resident's needs or wishes and implementing goals for discharge. And although the nurses' notes stated the "…resident was adapting well to the facility," this was contradictory to what the resident said. He was alert, capable and able to answer all questions about his care and needs.

4. Resident 11-03-04 was observed in the dining room being fed by a family member. He was observed with a long scab over his right eyebrow and there was a soft red helmet sitting on the table next to him. The family member stated he fell frequently and that she had been told the eyebrow wound was a reopened area from a previous fall. We later observed that this resident's

bed was on the floor and had a mat beside it, but we could not ascertain whether a wheelchair or bed alarm were being used. The resident's care plans were reviewed. He had at least four care plans that addressed his frequent falls. One plan had bed and chair alarms as interventions, however; there weren't any bed or chair alarms in place. His charge nurse was asked why the resident did not have bed and chair alarms. She stated that was a "good idea," but she would have to ask the physical therapy staff to provide them. There was a lack of communication between nursing and therapy staff and a lack of follow-through on necessary fall prevention measures. The resident's safety was in jeopardy, as evidenced by his recent injury.

Later, the resident was observed sitting in his wheelchair outside of his room with his helmet on. He smelled of urine and his room also smelled of urine. Many staff members passed by the resident, failing to pay attention to his needs.

5. The OG nurse observed Resident 11-03-5 positioned supine in bed with the head of the bed (HOB) at 40 degrees. Resident was unresponsive, not moving, and receiving nutritional support via continuous gastrostomy tube feeding. Cloudy yellow urine was observed draining from the Foley catheter. A bedside suction canister was in place, however; the machine was not connected appropriately for use in an emergency. The call light was clipped on her pillow out of reach.

Review of the facility's medial records indicate the resident was originally admitted on October 25, 2011 after an extensive hospitalizaiton for sttus post pulmonary embolism arrest, which occurred on August 22, 2011.

The resident had recently been sent to the hospital for evaluation on November 29, 2011 for a decrease in oxygen saturations. She was readmitted to the facility on November 23, 2011. There was nothing in the chart to indicate any new diagnosis since admission to the hospital. The hospital records were found in the facility chart and stated the resident was re-admitted to the hospital on November 19, 2011 for sepsis and a urinary tract infection (UTI) and pneumonia. The hospital History and Physical dated November 19, 2011 inicated the resident had an "unstageable sacrococcygeal skin lesion that "was noted on last admission."

After reviewing the records, and the facility's "October and November Pressure Ulcer Logs,"there was conflicting information about when and where the resident developed the wounds. The chart did indicate the following: 1) The October 2011 "Pressure Ulcer Log" stated the resident was admitted to the facility with a Stage II coccyx pressure ulcer. 2) The medical record contained hospital "Wound Care Nurse Consults. The hospital Consult dated October 14, 2011 noted a deep tissue injury to the sacrococcygeal area present on admission to the hospital. 3) A "Wound Care Consult" dated November 8, 2011 noted "*the deep tissue injury to the sacrococcygeal area has evolved into an unstageable pressure ulcer measuring 4.5 x 1.5 cm*." It was unclear if the resident had been readmitted to the hospital during October, 2011. It appears from the hospital records in the facility chart that the resident's deep tissue injuries occurred at the facility.

The facility nurses' notes stated the resident was readmitted to the facility on November 14, 2011 at 7:00 pm however; the notes do not indicate the reason the resident was admitted to the hospital, nor is there a new diagnosis. The facility's November, 2011 "Pressure Ulcer Log"

indicates the resident had three wounds on November 15, 2011: a Stage III to the sacrum, a deep tissue injury on the right buttocks and a deep tissue injury to the left buttocks.

The OG team was very concerned about the deficiencies in charting which make it difficult to accurately assess this resident's history. Additionally, this resident was never turned or repositioned during the OG inspection time.

6. During the OG facility walk-through, Resident 11-03-06 was observed by the team nurse lying on her right side in a fetal position. There was an odor at the resident's bedside indicating a possible infection. She was cachectic in appearance, emaciated and had labored breathing. Her nasal cannula was observed positioned on her chin. A CNA was asked by the team nurse to reposition the nasal cannula to the correct position. The CNA reported the resident was on "Comfort Care." The medical record was reviewed and showed the resident was a 46 year-old female with metastatic cervical cancer, lumbar vertebra fractures and abdominal pain. The Resident Admission Record indicated the resident was "Self-Responsible." The Physician Orders for Life-Sustaining Treatment (POLST) was signed by the resident and physician indicating she was a Do Not Resuscitate (DNR) and requested limited medical interventions in addition to care described in Comfort Measures Only- the use of medical treatment, antibiotics and IV fluids. She requested "no artificial means of nutrition, including feeding tubes, and wanted to be transferred to the hospital if comfort needs could not be met in the current location."

The facility's November Pressure Ulcer Log indicated the resident had acquired six pressure ulcers at the facility: left side of coccyx- was unable to determine (UTD), left hip-UTD, left inner knee- Stage II, right inner knee- Stage II, right hip- Stage I, and right shoulder- Stage II. The Weekly Pressure Ulcer Record dated November 28, 2011 indicated the left side of the coccyx pressure ulcer measured 2.2 x 2.0 cm and the stage was UTD, the left hip measured 4.0 x 2.0 cm and the stage was UTD, the right hip measured 1.8 x 1.0 cm and was a Stage I, the right shoulder measured 0.8 x 1.0 cm and was a Stage II, the inner knee wounds were noted to be healed.

The wounds were observed by the team OG nurse and the OG Doctor consultant. The wounds were observed to be infected and cellulitis was noted to the surrounding surface areas of all pressure ulcer sites. The pressure ulcers measured larger than the facility indicated, especially the coccyx wound which was measured only one day earlier. Due to the severity of the resident's wounds, her current medical status, and requested medical interventions in her POLST document, the team questioned the DON regarding the plan for the resident's care. The DON could not provide any medical information regarding the resident and had the charge nurse give the team a report. The charge nurse had been on vacation and had just returned to the facility the day we were there. Because there seemed to be so much confusion about the resident's current medical condition, the OG team requested the DON notify the resident's physician.

We inquired why the resident was not receiving Hospice services and the DON told us that the facility "did not have a current hospice contract, but the contract could easily be reactivated with Vitas." Review of the social services documentation indicated there were no notes recorded since September 12, 2011. There was no documentation indicating the social service employee had addressed end of life plans or Hospice services as the resident's condition had changed and deteriorated.

During our discussion with the Social Services person, it was noted that the facility was allowing this resident's boyfriend to make current medical decisions. We reminded the Social Services person that the boyfriend could not legally make medical care decisions for the resident, as the resident is "self-responsible."

The resident's physician arrived at the facility and in our discussion with him, he stated he had limited information about her end-of-life care wishes and the physician referred to the boyfriend as the "resident's husband." The physician stated he had discussions with the "husband" about her health care and that the "husband" was making the medical decisions. We informed the physician that the resident did not have a husband, that she was "self-responsible" and the individual he had been speaking to was in fact the resident's boyfriend.

The OG team and medical consultant had serious concerns that the facility was not providing appropriate end-of-life-care information and options --including hospice--to the resident as the resident's condition was deteriorating. After our discussions with the physician, it was clear the physician was not aware of the severity of the pressure ulcers and in fact had not seen the wounds until we were there. The team was concerned about the development and treatment of the pressure ulcers that occurred at the facility and the physicians' obvious lack of knowledge of his resident.

The resident agreed to be transported to the acute care hospital for further interventions of the infected wounds. The resident expired the following morning --November 30, 2011, at the acute care hospital.

A complaint was made to DPH regarding this resident's care.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. The hallway next to the dining room that leads to an exit door was cluttered with equipment on both sides of the hallway. This is a State Fire Code issue and safety hazard for the residents.

2. Many of the residents were observed without identification armbands. Several staff members were asked why the residents did not have identification bands and their response was the "medical records department was responsible to make and put on the identification bands but it was the nursing staff's responsibility to tell medical records when a band was needed." This is a safety issue for resident's unable to identify themselves.

3. The toilet base in bathroom 202 was very loose from the floor and could easily be moved. This is a safety hazard

4. The Resident in103A had oxygen being delivered at 4.5 L/min but there was no humidifier attached to the concentrator to assist in the resident's pulmonary comfort.

5. The bedside suction machine for Resident 105A had not been appropriately connected for use in

an emergency situation. According to the resident's medical chart, the resident had been residing in the room since her re-admission from the hospital on November 23, 2011. This is a health and safety issue.

6. Linen closets contained minimal linens and blankets for the residents.

7. The Medication Room located at the North Station was found unlocked and the OG team nurse was able to enter the room. The Medication Room contained unlocked cabinets including stock medications, discontinued medications, and emergency medications. This issue was immediately brought to the attention of the North Station charge nurse and later to the attention of the DON.

8. Several residents were observed by the OG team with their call lights out of reach. This is a potential neglect issue.

9. The posted menu on the facility bulletin board read "Spring/Summer 2011." The residents were observed being served foods listed on those plans. There was a concern that residents had been receiving the same foods over an extended period of time. Many residents complained about the quality of the food.

10. There were several rooms that did not have the names of the residents posted outside the rooms. This is a potential safety issue.

ADMINISTRATIVE OBSERVATIONS:

1. The facility did not have a Director of Staff Development.

2. There were no infection control reports in the facility's binder for September and October 2011.

STAFFING:

Based on the records provided by the facility, staffing levels were **below** the 3.2 hours per resident day (hprd) on **three** of the **six** days randomly reviewed. The average hprd was 3.22 hours.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. If you have any questions or any comments, please contact Cathy Long NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 274-2913 or Peggy Osborn at (916) 263-2505.

Physician's Report – Operation Guardians
Kathryn Locatell, MD
December 5, 2011

Florin Health Care Center
November 29, 2011

I. Summary

The care of thirteen current or former residents was reviewed. Deficient resident care and resident care practices were identified in almost every case. Because the facility's population includes a relatively large number of younger individuals, failures of discharge planning have to potential to adversely affect many residents. It did not appear that rehabilitation services were being provided to the extent claimed by the facility. Nursing care was deficient likely due to understaffing and lack of supervision of nursing staff.

II. Pressure ulcer prevention and treatment

One resident reviewed acquired two full-thickness pressure sores after her admission to the facility. Her record lacked evidence that needed care had been rendered to prevent these wounds; they were thus clinically avoidable. Resident 8, age 46, was admitted to the home for supportive care on 9/1/11 and her skin was intact upon admission. She was suffering from advanced metastatic cervical cancer but had not elected to receive only palliative care. On examination, the sacral wound had a significant odor and surrounding redness and appeared to be infected. Although a physical therapy assistant documented having debrided the wounds, both the sacral wound and the left hip wound contained a large amount of necrotic tissue. The resident appeared to be near death at the time of our examination, but the advance-planning preferences documented in her chart indicated that she still wished to receive antibiotics and other interventions. The narrative record lacked evidence that nursing staff had considered her advance directives in formulating their plan for her care.

III. End of life care

According to the director of nurses, the facility has a contract with one hospice agency, but the contract was "old". Among four residents reviewed (Residents 5, 8, 12 and 13), hospice care was clearly indicated, yet the record lacked evidence that it had been considered or offered, either by the facility or by attending physicians. Based on documentation in these residents' charts, the end of life care being rendered by the facility does not meet generally accepted standards of quality.

Resident 5 was suffering from end stage renal disease and had refused dialysis. She was admitted from an acute care hospital, whose records are contained in the facility chart. The resident had very little kidney function and an elevated potassium level at the hospital, which meant that without dialysis, her death would occur in a short period of time, days in my estimation. However, the narrative nurses' notes lack any evidence that nurses were aware that the resident was dying; in fact, there was very little charted about her condition at all during the week-long residence. The facility was billing Medicare Part A for skilled nursing and rehabilitation services, whereas her record does not support a contention that this level of care was either necessary or even provided.

Resident 8, after 3 months in the home, was near death from metastatic cervical cancer on the day of our inspection. There were very few social services notes, and although the resident possessed the capacity to make decisions about her future treatment for much of her residence, there had been no exploration or determination by anyone at the facility of what her wishes were for end of life care. Instead, decisions were being made by her boyfriend, with no legal documentation present in the chart supporting his ability to do so. Her attending physician, whom we interviewed, stated that he was not her "primary care" doctor and that such decisions were to be made by outside physicians. He acknowledged that in her current condition she was not able to leave the facility for any other doctor to evaluate her and her care needs, and subsequently discussed her condition with her boyfriend, which resulted in Resident 8's transfer to the hospital. Resident 8 did not receive quality care and likely her wishes for end of life care were ignored. Additionally, there was no evidence that the facility obtained consent for a physical therapy assistant to debride her pressure ulcers.

Residents 12 and 13 were both admitted for terminal care, yet also were not referred to hospice; instead, the facility billed Medicare Part A for skilled nursing and rehabilitation. In the case of Resident 13, the facility documented performing over 700 minutes of physical, speech, and occupational therapy in the first Minimum Data Set, covering his first 5 days in the facility. The facility continued to document providing therapy services through the day of his death, just 13 days after admission. Five days before his death, he had facial grimacing and moaning, making it very unlikely that he could participate in, or benefit from, rehabilitation services. Based on review of these 4 cases, end of life care is grossly deficient.

IV. Fall prevention

Residents 1 and 7 have both had numerous falls, and deficient care is evident in each case. Resident 1, age 53, has been residing at the facility since 1/12/11. In just the past 6 weeks she has experienced 4 falls. Review of the chart shows that each was unwitnessed. The evening prior to our inspection, Resident 1 was found on the floor outside of an exit door; she was a smoker, but according to her care plan was to have supervision while smoking. There was no documentation in her record that explained out and why Resident 1 got outside with no supervision. The resident's care plan lacked meaningful, individualized interventions to prevent this resident from falling repeatedly.

Resident 7 has a number of planned interventions listed in his care plan to prevent additional falls. A "head guard" is being used to prevent head injury from falling, but his most recent fall, on 11/26, resulted in a care plan that states his helmet was to be worn when he was up in the chair, whereas a previous care plan dated 10/16 states that his head guard was to be worn at all times. The resident required emergency medical care on 11/26, for a "deep cut" on the right side of his forehead, according to the transfer record, that needed stitches, which obviously had to have resulted from a hard blow to the head which likely would have been prevented had the head guard been in place. The facility characterized the cut as a "reopened old wound" in the narrative notes, but the last facial wound occurred many weeks prior and had healed fully as of 11/26. In Resident 7's case, there was no evidence that his care plan was being carried out, or that nursing staff recognized that a "deep cut" requiring stitches was a serious injury necessitating further interventions to protect Resident 7's safety.

V. Protection from harm

The facility appears to have deviated substantially from generally accepted standards in its efforts to keep residents safe, from falling and other avoidable harm. There were gross failures in the cases of Resident 1 and Resident 9.

Resident 1 was thought to have been sexually assaulted by another resident on 3/1/11. The resident has difficulty expressing herself due to a prior stroke. Nursing staff completed a report of suspected elder abuse according to a narrative entry in the nurses' notes, however, not a single licensed nurse documented any physical assessment of Resident 1 at the time the assault was reported or in subsequent "change of condition" charting. The resident had indicated that the other resident ("in 613B") had molested her breast and perineal area by answering yes or no questions; however, the incident was unwitnessed according to the narrative entry, so it is unclear how a staff person knew that this resident had been "sitting next to her", where, or at what time. As noted above, it appears that Resident 1 was being allowed to smoke outside unsupervised, and it seems likely that this event occurred when Resident 1 and the resident from 613B were both outside unsupervised. Because the incident was unwitnessed, and the resident incapable of describing what happened, the facility should have, at a minimum, conducted a thorough physical assessment of Resident 1, if not sent her to an emergency department for a rape examination.

Resident 9 eloped from the building on the day of our inspection, and the elopement was witnessed by a team member. This 66 year old woman has a conservator, and therefore by definition lacks the capacity for self-preservation; she is at very high risk for injury and death while outside the facility near a busy street. It was observed that her Wanderguard device failed to cause the alarm to sound when she exited the building, but it did sound as she returned. There is no evidence that anyone had verified that the Wanderguard was functioning properly. The resident was admitted to the facility on 8/8/11, was independent in most of her activities of daily living, and was ambulatory without any assistive devices. She was known to be at risk for elopement beginning on admission, yet the Wanderguard was not ordered by her physician until 11/28, despite at

least two prior elopements, on 9/5 and 11/10. There was no means in place, at the time of our inspection or prior to our inspection, for the facility to prevent this vulnerable resident from exiting unsupervised.

VI. Discharge planning

There does not appear to be any process in place to assist residents in returning to the community, in gross violation of prevailing standards of care. I did not find a care plan for discharge planning in any of the residents' records I reviewed, including Resident 4. This 53 year old is independent in most of her activities of daily living, and is receiving wound care to skin ulcers on her lower extremity. Resident 4's "stated goal" for discharge was to return to her mother's home when her ulcers had healed. However, I could find no indication that such care could not have been provided on an outpatient basis, and I could find no justification for this resident to have to live in a nursing home to get wound care. She has been residing at the facility since 10/15/11.

Resident 11, a veteran, was admitted on 9/16/11 after a series of hospitalizations and another nursing home stay after a hip fracture. He is 66 years old and had been homeless at the time he was struck by a car while riding his bicycle, resulting in the hip fracture. His medical history was notable primarily for chronic mental illness. It is unclear whether he has been determined to possess decisional capacity, since the medical record shows that at times his brother is acting for him (e.g., signed the consents for an antipsychotic drug) and at others he is making his own decisions (e.g., signed his advance directive document, the POLST form). Although the facility was providing skilled care, including rehabilitation, and billed Medicare Part A for the first 4 weeks of his residence, at the first care conference held 6 days after admission, it was noted that he had applied for Medi-Cal and that he was likely to remain in long term care with "possible discharge". There was no care plan concerning possible discharge, and the social services notes contained only one cryptic entry that his discharge plan was "LTC vs. VA psychiatry care". The failure to assess and assist the resident in determining his preferences is typical of a pattern observed in other cases: the facility chooses to keep individuals like Residents 4 and 11 as long-term residents rather than assisting them in placement in the community.

VII. Rehabilitation services

I began monitoring the rehab room at mid-morning when I noted at least 5 therapy staff sitting around a table, laughing, with no residents present in the room receiving therapy services. I obtained a copy of the master schedule for the day, which shows that 7 therapy staff were scheduled for 8 hours each and one staff was to work a half-day. There were 31 residents on the list to receive therapy services. However, through periodic observation of the room, I continued to observe zero to 3 at most residents present in the room. One resident was playing a Wii game by himself. I continued to observe most of the therapy staff sitting around the table, and on occasion I saw staff at the nursing station or walking back and forth in the hallways. I did not observe therapy staff in residents' rooms providing treatment. A licensed nurse stated in an interview that

the rehab director had been fired and that therapy staff did not provide bedside treatment such as assisting residents with transferring out of bed or performing activities of daily living; instead, therapy staff insisted that nursing get the residents out of bed and perform their ADLs before the therapy staff would treat them. After review of a number of medical charts where the medical necessity for rehab was questionable at best, it appears that the rehabilitation service the facility is claiming payment for are not being performed at the levels claimed.

VIII. Nursing services and staffing

The types of failures observed and described in this report suggest that nurse staffing is inadequate at the present time, in actual numbers, in training, in supervision, or a combination of these elements. Licensed nurses are not conducting pertinent assessments but rather are documenting rote narrative entries devoid of meaningful information. Licensed nurse documentation elsewhere is also deficient, with mindless box-checking (e.g., "0" side effects every shift for a drug that was not being administered) and inconsistent care plans. There do not appear to be sufficient CNAs to meet resident care needs, particularly considering the numbers of younger residents with chronic mental illnesses, smokers, and persons at risk for elopement.

I obtained copies of "Weekly Key Factor" reports, submitted by the facility to "corporate", which demonstrate facility staffing and budgeting for staff for the time frame 9/29 to 11/2/11. I also obtained copies of the facility's internally calculated nursing hours per resident per day, documents that had been posted on a daily basis, for the month of November. The census ranged from 108 to 114, with usual CNA-to-resident ratios of approximately 1:8 for the day shift, 1:12 for the evening shift, and 1:16 for the night shift. Direct care licensed nurses provided an average of about 0.7 hours of LVN time and 0.4 hours of RN time per resident per day. The facility's budget for total direct-care nursing hours is 3.205. While the posted "PPD" never fell below the state minimum, the actual nursing hours per resident per day and certainly the budgeted PPD is insufficient for the population and types of residents served by this nursing home. While the facility chooses to accept high-care need residents, at risk for falls, elopements, in need of protection due to chronic mental illness, it is not providing nurse staffing to meet generally accepted standards of quality for these residents.

IX. Conclusions

Numerous aspects of resident care are deficient in this nursing home at the present time. Direct care nurse staffing is insufficient for the population, resulting in avoidable harm to residents and placing a large number of residents at risk. Social services and rehabilitation services appear almost nonexistent.